STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			08/24/2	011
			P		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER				IPLEY STREET		
LAKE PA	RK RESIDENTIAL (	CARE INC		1	STATION, IN46405		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
R0000							
		r the Investigation of	R(	0000			
	Complaint IN000	094623.					
	Complaint INIOO	094623-Substantiated.					
	^						
		deficiencies related to the					
	-	ed at R0036, R0045,					
	R0090 and R009	1.					
	Survey dates: August 23 and 24, 2011						
	Facility number:	001136					
	Provider number						
	AIM number:	N/A					
	Survey team:						
	Kelly Sizemore,	RN-TC					
	Regina Sanders,						
	Sheila Sizemore,						
	Shena Sizemore,	KIV					
	Census bed type:						
	Residential: 128						
	Total: 128						
	10141. 128	1					
	Census payor:						
	Medicaid: 117						
	Other: 11						
	Total: 128						
	Residential samp	sla: 3					
	Residentiai samp	DIC. 3					
	These state reside	ential findings are cited					
		th 410 IAC 16.2.					
	in accordance wi	110 11 10 10.2.					
LABORATOR	Y DIRECTOR'S OR PROV	TIDER/SUPPLIER REPRESENTATIVE'S SIC	SNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HEV011 Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF  A. BUILDING 00 COMPLETI  B. WING 08/24/201			ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2075 RIPLEY STREET  LAKE STATION, IN46405				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
R0036	(k) The facility must resident 's physician representative who (1) a significant dephysical, mental, (2) a need to alter is, a need to discotreatment due to a commence a new Based on record facility failed to physician and legaresident moving middle of the nigrecords reviewed representative not 3. (Resident B)  Findings include  Resident B's clos on 8/24/11 at 9:3 diagnoses include	ompleted on August 29, alkner, RN  set immediately consult the fain and the resident's legal en the facility has noticed: ecline in the resident's or psychosocial status; or treatment significantly, that notinue an existing form of adverse consequences or to form of treatment. review and interview, the notify a resident's gal guardian related to a out of the facility in the each, for 1 of 3 closed a for physician and legal patification in a sample of	ROO	TAG 036	1. What corrective actions wi accomplished for those resid found to have been affected the deficient practice. Based of the descriptions given in the Summary Statement of Deficiencies and no key of identifers given by survey teafacility assumed who residen are: Resident B no longer res at Lake Park Residential and facility was informed by guard that resident would not be returning and will be placed in group home. 2. How will the faidentify other residents having potential to be affected by the same deficient practice and we have the same deficient practice.	II be ents by on ts ides dian acility g the	10/11/2011
	An undated incide the Administrato				corrective action will be taker residents of Lake Park Residential have the potential be affected by this alledged deficient practice. The Nursing Staff will be inserviced on identifying changes in residential process.	ıl to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **HEV011** Facility ID:

001136

If continuation sheet

Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2075 RIPLEY STREET LAKE PARK RESIDENTIAL CARE INC LAKE STATION, IN46405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Incident time midnight or after...Brief behaviors. The Nursing Staff will be inserviced on notifying a Description of Incident: Resident was residents physician and legal observed by another resident moving her representative in a timely manner personal items...into the vehicle...of a when there has been a change in resident behavior and if the former male resident...this was done at resident leaves the building approx (approximately) 12 midnight or without signing out ot notifying later..." staff.3. What measure will be put into place or what systemic The first documentation in the nurses' changes the facility will make to ensure that the deficient poractice notes was on the following date and does not recur. The Director of times, Nursing will randomly check clinical records to ensure that 8/2/11 at 12:30 a.m., "called daughter re: resident's physician and legal representative where applicable whereabouts-got voicemail left message will be notified of a change in per requested by administrator." residents behavior.4. How the corrective action will be monitored to ensure the deficient 8/2/11 at 6:40 a.m., "Daughter called-has practice will not recur. The not seen mother as of this time..." Director of Nursing will randomly check clinical records and will 8/2/11 at 9:00 a.m., "Resident remains monitor for compliance.5. By what AWOL (absent without leave)..." date the systemic changes will be completed.October 11, 2011 There was a lack of documentation in the nurses' notes the resident's physician and guardian had been notified in a timely manner that the resident had left the facility. During an interview with the Administrator, on 8/23/11 at 12:00 p.m., she indicated she had notified the resident's guardian on 8/1/11 but was unsure of the time.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMI 08/24/	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIEF		2075 R	ADDRESS, CITY, STATE, ZIP COE IPLEY STREET STATION, IN46405	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	During an interv guardian, on 8/2 indicated the Ad	iew with Resident B's 4/11 at 10 a.m., she ministrator contacted her was unsure of the time.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
			A. BUIL			08/24/2	011
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				IPLEY STREET		
IVKEDV	.RK RESIDENTIAL (	CAPE INC			STATION, IN46405		
	INN NESIDENTIAL (	BAIL INC		LANL	51A11ON, 1140403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	ļ	TAG	DEFICIENCY)		DATE
TAG R0045	(6) Before an interioccurs, the facility by the department. (A) Notify the resid discharge and the writing, and in a lat the resident undersumst place a copy 's clinical record a following: (i) The resident. (ii) A family member (iii) The resident 's known. (iv) The local long program (for involutional for involutional for involutional for involutional formation of the division of directional for enabilitative service placement decision (vii) The resident 'transfer or discharges only). (v) The person or a resident 's placement decision (vii) The resident 'transfer or discharges only). (vi) In situations will developmentally direction of directional for enabilitative service placement decision (vii) The resident 'transfer or discharges under subdivision (4)(C), (B) Record the reactionical record. (C) Include in the reaction of transfer or discharges only). (7) Except when system of the notice of transfer under subdivision facility at least thirt resident is transfer (8) Notice may be practicable before (A) the safety of in	lent of the transfer or reasons for the move, in inguage and manner that stands. The health facility of the notice in the resident ind transmit a copy to the resident individuals in the facility of the resident if known. It is legal representative if the sterm care ombudsman antary relocations or reagency responsible for the lent, maintenance, and care the resident is isabled, the regional office isability, aging, and ces, who may assist with ins. It is physician when the ge is necessary under (4)(D), (4)(E), or (4)(F). It is sons in the resident in the resident in the resident in subdivision (8), for or discharge required (6) must be made by the control of the red or discharged. It is made as soon as transfer or discharge when: dividuals in the facility		TAG	DEFICIENCY)		DATE
	would be endange (B) the health of in	dividuals in the facility					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WINC			08/24/2	011
		<u> </u>		_	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIEF	8			IPLEY STREET		
LAKE PA	RK RESIDENTIAL	CARE INC			STATION, IN46405		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	<del>                                     </del>	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	would be endange	•					
		s health improves sufficiently					
		nmediate transfer or					
	discharge;	transfer or discharge is					
		sident 's urgent medical					
	needs; or	oldent o digent medical					
	· ·	not resided in the facility for					
	thirty (30) days.						
		lities, the written notice					
	specified in subdiv	vision (7) must include the					
	following:						
		r transfer or discharge.					
		date of transfer or discharge.					
		o which the resident is					
	transferred or disc						
		not smaller than 12-point					
		ds, " You have the right to facility 's decision to					
		u think you should not have					
		y, you may file a written					
		ing with the Indiana state					
		alth postmarked within ten					
	(10) days after yo	u receive this notice. If you					
	request a hearing	, it will be held within					
		days after you receive this					
	1	ill not be transferred from					
		than thirty-four (34) days					
		this notice of transfer or					
		the facility is authorized to					
		r subdivision (8). If you wish sfer or discharge, a form to					
	1 ' '	facility's decision and to					
		is attached. If you have any					
		Indiana state department of					
	•	ber listed below. " .					
	(E) The name of t	he director and the address,					
		r, and hours of operation of					
	the division.						
		lest form prescribed by the					
	department.						
	(G) The name, ad	dress, and telephone					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			08/24/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	3		1	IPLEY STREET		
Ι ΔΚΕ ΡΔ	RK RESIDENTIAL	CARE INC		1	STATION, IN46405		
					TATION, INTOTOS		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		te and local long term care					
	ombudsman.	ility regidents with					
		ility residents with sabilities or who are mentally					
		dress and telephone number					
		and advocacy services					
	commission.	,					
	3. Resident C's	closed record was	R(	045	What corrective actions with		10/11/2011
	reviewed on 8/2	4/11 at 8:55 a.m.			accomplished for those reside found to have been affected		
	Resident C's dia	gnoses included, but were			the deficient practice?Based	•	
	not limited to, so	chizophrenia,			description given by Stateme		
	hypertension, and emphysema.				Deficienies and no resident		
					identifier key given by Survey		
	A physician's or	der, dated 7/27/11,			Team-Resident B left the fac	-	
	indicated "ok D/				without notifying the facility s		
		` • /			until after leaving and no long resides at Lake Park	Jei	
	community (hali	tway nouse)			Residential.Resident C was		
		1 - 1 - 10 0 11 0 0 0 0			voluntarily discharged from the	ne	
	1	lated 7/28/11 at 10:00			facility and no longer resides		
	•	Resident left facility via			Lake Park Residential.Resid		
	facility driver to	(name of group home)			was voluntarily discharged fr		
	with medication	record-chest x-ray."			facility and notified facility at time of leaving facility and no		
					longer resides at Lake Park	,	
	Resident C's rec	ord lacked documentation			residential2. How the facility	will	
	of a Notice of Ti	ransfer/Discharge form.			identify other reisdents havin		
		5			potential to be affected by the	e	
	During an interv	riew the DoN indicated on			same deficient practice and		
	_	a.m., "I understand this is			corrective action will be take		
		i.iii., 1 uiiucistaliu tiiis is			resident have the potential to		
	an issue."				affected by this alledged defi practice. All Nursing Staff will		
					inserviced on the Notice of	ne	
					Discharge/Transfer Form and	d l	
					nursing staff will complete th		
					form upon discharge.3. Wha		
					measures will be put into pla		
					what systenic changes the fa	cility	
					will make to ensure that the		
					deficient practice does not		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/24/2011
	ROVIDER OR SUPPLIER		STREET. 2075 R	ADDRESS, CITY, STATE, ZIP CODE RIPLEY STREET STATION, IN46405	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to a Notice of Trans which informs the reason and desting the appeal rights discharged reside (Residents #B, #Findings includes 1. Resident #D's reviewed on 08/2 resident's diagnores	,		recur.The Director of Nursin and/or designee will initiate a discharges and will ensure the resident being discharge given the Notice of Transfer/Discharge Form will every discharge.4. How will the corrective action be monitored ensure the deficient practice not recur. The Nursing Staff notify the Director of Nursing any anticipated discharges at the Director of Nursing will provide a copy of Notice of Transfer/Dischrage Form to Administrator with very discharges.5. By what das systemic changes will be completed. October 11, 2011	all hat hat hat hed is  th he ed to will will g of and  the he h

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HEV011 Facility ID:

001136

If continuation sheet

Page 8 of 16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			08/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
IVKE DV	RK RESIDENTIAL (	CARE INC		1	IPLEY STREET STATION, IN46405		
					1A110N, IN40403		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		dated 07/08/11 at 11:30	+	1110			DITTE
	· ·						
	a.m., indicated the resident was discharged to an adult foster care.						
	discharged to an	addit foster care.					
	   There was a lack	of documentation to					
		ent had been given a					
		er/Discharge form to					
	inform the reside	•					
		ppeal rights for the					
	transfer.	ppeur rights for the					
	transier.						
ı	2 Resident #B's	closed record was					
		24/11 at 9:30 a.m. The					
		ses included, but were					
	I -	hizo-affective disorder					
	and bipolar mani						
		e disorder.					
	A physician's ord	ler, dated 08/11/11,					
		dent was discharged to					
	an outside facilit						
	an outside idenii	<i>y</i> .					
	There was a lack	of documentation to					
		lent had been given a					
		er/Discharge form to					
	inform the reside	C					
		ppeal rights for the					
	transfer.	ppeur rights for the					
	tiungion.						
	   During an intervi	iew on 08/24/11 at 10:55					
	_	or of Nursing indicated					
		of what the Notice of					
		ge form was. She					
		dents did not get the					
	information for the	_					
	miormanon ioi t	ne discharge.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					00	COMPI	
				LDING		08/24/2	011
			B. WIN		DDDEGG CITY GTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
	DI DECIDENTIAL	OADE INO		1	IPLEY STREET		
LAKE PA	RK RESIDENTIAL	CARE INC		LAKES	STATION, IN46405		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0090	(g) The administra	tor is responsible for the	1				
	overall manageme	ent of the facility. The					
	responsibilities of	the administrator shall					
		ot limited to, the following:					
		livision within twenty-four					
		oming aware of an unusual					
		rectly threatens the welfare,					
		f a resident. Notice of ce may be made by					
		ed by a written report, or by a					
		that is faxed or sent by					
		the division within the					
		our time period. Unusual					
	, ,	de, but are not limited to:					
	(A) epidemic outb						
	(B)poisonings;	,					
	(C) fires; or						
	(D) major accident	ts.					
	If the division canr	not be reached, a call shall					
	be made to the en	nergency telephone number					
	published by the d						
		ging for or assisting with the					
		al, dental, podiatry, or					
	-	ner health care services as					
	requested by the representative.	resident or resident's legal					
	•	ctor approval prior to the					
		dividual under eighteen (18)					
	years of age to an	• , ,					
		acility maintains, on the					
		rate record of actual time					
	worked that indica	tes the:					
	(A) employee's ful	I name; and					
		rs worked during the past					
	twelve (12) month						
		sults of the most recent					
	•	he facility conducted by					
		ny plan of correction in					
	·	to the facility, and any					
		ys. The results must be ination in the facility in a					
		ssible to residents and a					
	Piace readily acce	coibic to residents and a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HEV011

Facility ID:

001136

If continuation sheet

Page 10 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2075 RIPLEY STREET LAKE PARK RESIDENTIAL CARE INC LAKE STATION, IN46405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request 1.What corrective action will be Based on record review and interview, the R0090 10/11/2011 accomplished for those residents facility failed to report an unusual found to have been affected by occurrence within 24 hours of an incident the deficient practice. Based on related to a resident leaving a facility, for the description in the Summary Statement of Deficiencies, it can 1 of 3 resident closed records reviewed only be assumed who Resident B for reporting incidents in a sample of 3. is, due to identifier key not given (Resident B) by survey team at exit.Resident B no longer resides at Lake Park Findings include: Residential.2. How the facility will identify other residents having the potential to be affected by the An undated policy titled, "UNUSUAL same deficient practice and what OCCURRENCES-POLICY & corrective action will be taken.All residents have the potential to be PROCEDURES." received as current affected by this alledged deficient from the Administrator, on 8/24/11 at 8:30 practice. All staff will be inserviced a.m., indicated "All unusual occurrences on reporting unusual occurences (covered in the ISDH P & P (policy and to the Administrator within two procedures) will be reported to the hours of occurence.3.What measures will be put into place or Administrator within two hours of what systemic changes the facility occurrence...On weekends either the will make to ensure that the Evening Supervisor or RN will be deficient practice does not responsible for contacting the recur?Unusal occurences will be documented on the 24 hour Administrator..." There is lack of report form to ensure that all documentation in the policy regarding nursing staff are aware of any when the Administrator should report unusal occurence that has unusual occurrences to ISDH. occured .4.. How will the corrective actions be monitored to ensure the deficient practice will Resident B's closed record was reviewed not recur. The Administrator on 8/24/11 at 9:30 a.m. Resident B's and/or designee will randomly diagnoses included, but were not limited audit clinical records and 24

l l		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
			B. WIN	G		08/24/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF I	NO VIDER OR SETTEIER				IPLEY STREET	
LAKE PA	RK RESIDENTIAL (	CARE INC		LAKE S	STATION, IN46405	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		disorder, diabetes, and			hours reports for documenta	
	schizoaffective d	lisorder.			of occurences. Administrator and/or designee will inform	
					residents at resident council	
	An undated incid	lent report filled out by			meeting that any incidents o	.
	the Administrato	r, indicated "Incident date			concerns should be reported	to
	Sunday July 31st	t, Monday Aug. 1st, 2011,			the staff and/ or Administrator.5.By what date	the
	Incident time mid	dnight or afterBrief			systemic changes will be	; u1C
	Description of In	cident: Resident was			completed. October 11, 2011	
	observed by anot	ther resident moving her				
	personal itemsi	into the vehicleof a				
	former male resid	dentthis was done at				
	approx (approxir	mately) 12 midnight or				
	later"					
	Review of a facs	imile transmittal sheet				
	indicated the ISE	OH (Indiana State				
		ealth) was notified on the				
	1 ^	5, 2011 and August 8,				
	2011.	,				
	During an intervi	iew with the				
	_	n 8/23/11 at 11:55 a.m.,				
	I	other resident told her the				
		ne came into work about				
	1	ng her things in a van.				
	Pattil					
	During an intervi	iew with the				
	~	n 8/23/11 at 12:10 p.m.,				
	·	e notified ISDH, APS				
		e Services) and the				
	Ombudsman the	,				
	Jinouusinan me	noat day.				
	During a telepho	ne interview with APS on				
		.m., they indicated they				
	1 0/23/11 at 1.20 p	.m., mey mureated they				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 00 COMPLETEI  B. WING 08/24/2011			ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY STREET LAKE STATION, IN46405				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
R0091	(h) The facility sha a written policy ma care and facility of attained, to include (1) The range of st. (2) Residents' right (3) Personnel adm. (4) Facility operation. The policies shall be residents upon record facility failed to a procedure was for administrator of a related to a reside facility in the mid 3 closed records in a sample of 3.  Findings include Resident B's close	the facility on 8/5/11.  Ill establish and implement anual to ensure that resident ojectives are enthe following: ervices offered. ts. pinistration. ons. be made available to quest.  Treview and interview, the ensure the policy and ollowed for notifying the an unusual occurrence ent moving out of the ddle of the night, for 1 of reviewed for discharges (Resident B)	R009		1. What corrective action will accomplished for those reside found to have been affected by the description in Summary Statement of Deficiencies, it is assumed whom Resident B is due to no identifer key given survey team upon exit.Reside no longer resides at Lake Par Residential.2.How will the fact identify other residents having potential to be affected by the sale deficient practice and who corrective action will be taker reisdents in the facility have to potential to be affected by this	be ents by be sility g the enat h.All he	10/11/2011
		ed, but were not limited			alledged deficient practice.All		
	to, bipolar manic				staff of Lake Park Residentia including registry nursing state		
	schizoaffective d				will be inserviced on the police regarding residents leaving the	y ne	
	OCCURRENCE	ry titled, "UNUSUAL S-POLICY & " received as current			building. 3. What measures we be out into place and what systemic changes the facility make to ensure that the deficience.	will	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
			B. WIN			08/24/2	011
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			IPLEY STREET		
LAKE PA	ARK RESIDENTIAL	CARE INC			STATION, IN46405		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	from the Admin	istrator, on 8/24/11 at 8:30			practice does not recur.Nurs		
	a.m., indicated "	All unusual occurrences			Staff and Security Staff will n		
	(covered in the I	SDH P & P (policy and			rounds hourly and will report any resident leaves the build		
	`	be reported to the			after 1:00AM. Staff will repor		
	1 *	ithin two hours of			residents observed leaving the		
	occurrence"	Time two nodes of			building to the Charge Nurse		
	occurrence				duty who in return will report		
	Am ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	litro maliaro titlad			incident to Director of Nursin	g	
	An undated facil				and Administrator and will		
	"RESIDENTS L				document incident in clinical records and 24 hour nursing		
	· ·	ceived as current from the			report form.4.How will the		
		n 8/24/11 at 8:15 a.m.,			corrective action be monitore	ed to	
	indicated "TH	E POLICY IS			ensure the deficient practice	will	
	RESIDENTS M	AY LEAVE THE			not recur.Director of Nursing		
	BUILDING BU	T MUST BE IN THE			review 24 hours report forms		
	BUILDING BY	1:00 AM"			weekly and will randomly che	eck	
					clinical records and report findings to		
	An undated incid	dent report filled out by			Administrator.Administrator v	vill	
		or indicated "Incident date			monitor for compliance.5. By		
					date the systemic changes w		
	1	t, Monday Aug. 1st, 2011,			completed.October 11, 2011		
		dnight or afterBrief					
	_	ncident: Resident was					
	1	ther resident moving her					
	personal items	into the vehicleof a					
	former male resi	dentthis was done at					
	approx (approxi	mately) 12 midnight or					
	later"						
	The resident's re	cord lacked					
		he Administrator was					
	notified of the resident leaving the						
	building with her belongings.						
	D. since (1.1)	0/04/11					
		one interview, on 8/24/11					
	at 11:15 a.m., Se	ecurity Guard #3,					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY  COMPLETED  09/24/2011				
			B. WING		08/24/2011			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2075 RIPLEY STREET					
LAKE PA	RK RESIDENTIAL	CARE INC	LAKE	STATION, IN46405				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	PROPRIATE	LETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	Y) DATE			
		2 had told him Resident						
		r refrigerator and						
		d got into a van with her						
	-	ndicated he immediately						
		t B's room and Resident						
	_	he immediately reported						
	it to the nurse on	uuty.						
	During a telepho	one interview, on 8/24/11						
		N #1 indicated, CNA #2						
	·	r the resident was not in						
	the building.	THE TOURSE WAS TOUR						
	and containing.							
	During an interview, at 8/23/11 at 12 p.m., the Administrator indicated the nurse did not call her when the incident occurred. She indicated the incident was passed on in shift report but was unsure what time she was notified on 8/1/11.							
	During an interview on 8/24/11 at 10:47							
		Director of Nursing)						
		se did not follow the						
	policy. She indicated the nurse should							
	have called the A	Administrator.						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 08/24/2011			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  2075 RIPLEY STREET  LAKE STATION, IN46405					
				1	•			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION (X5) LD BE ROPRIATE COMPLETIC DATE	ON		